#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2007 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIF   | PLE CONSTRUCTION<br>3 | (X3) DATE SURVEY<br>COMPLETED  |                      |   |  |
|---|--|---|-----------------------|--|----------------------|---|--|
| 09G046  |  | B. WING   |                       | BE (4.0 (20.07   |                      |   |  |
|   | ROVIDER OR SUPPLIER  |   | 46                    | EET ADDRESS, CITY, STATE, ZIP CODE<br>601 GEORGIA AVENUE NW<br>/ASHINGTON, DC 20011                    | 05/10/2007           |   |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE              | (X5)<br>COMPLETION<br>DATE                            |  |
| W 000   | INITIAL COMMEN   | TS  | W 000                 |  |                      |   |  |
| W 104   | 8, 2007 through Mainitiated using the trandom sample of a resident population disabilities. The first based on observational staff in the home at a review of clier including incident rule 483.410(a)(1) GOV. The governing body budget, and operations of the standard operations operations of the standard operations operations of the standard operations o | VERNING BODY  ly must exercise general policy, ting direction over the facility.  is not met as evidenced by: tions, interviews and review of 's governing body provided direction over the facility, | W 104                 |  | 2007 HAY 30 A 10: 37 | DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION |  |
| W 120   | maintenance of the evidenced by:  a. Rust on the fen the facility.  483.410(d)(3) SER OUTSIDE SOURCE   | ly failed to ensure the e facility's environment, as cing around the perimeter of RVICES PROVIDED WITH SES  | W 120                 |  |                      |   |  |
| ORATOR  | Y DIRECTOR'S OR PROVI  | DER/SUPPLIER REPRESENTATIVE'S SIGN  | ATURE                 | TITLE  |                      | (X6) DATE   |  |
|   | _ Come   | y Styphen   |                       | President  |                      | 5/23  |  |

ovide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1, ,              | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |                                   | JRVEY<br>TED               |
|--------------------------|--|--|-------------------|--|---|-----------------------------------|----------------------------|
|                          |  | 09G046   | B. WIN            | IG                                     |   | 05/1                              | 0/2007                     |
|                          | ROVIDER OR SUPPLIER  |  |                   | 46                                     | REET ADDRESS, CITY, STATE, ZIP CODE<br>601 GEORGIA AVENUE NW<br>VASHINGTON, DC 20011  | •                                 |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO)<br>CROSS-RÉFERENCED TO THE APPR<br>DEFICIENCY)  | ULD BE                            | (X5)<br>ÇQMPLETION<br>DATE |
| W 120                    | This STANDARD in Based on observation home and day program the facility failed to met the needs of oil sample. (Client #3)  The facility failed to program was provide treatment.  The findings include the program was provide treatment.  The findings include the program was provided up from the with day program is approximately 1:15 hoards items that his program. The day program. The day program. The day program is the day program is the day program. See the daily. Day program is program indicate hoarding and the day progr | s not met as evidenced by: ion, interviews with group fram staff, and record review, ensure that outside services ne of the four clients in the ensure that Client #3's day ding continuous active | W                 |  | A meeting was held wit Q.M.R.P. & Day Progr. Psychologist / behavior specialist on 05/11/07 to address client # 3's hoar behavior.  A new BSP will be develoge by the day program on 05/30/07 during their Bl. HRC meeting. In- service be given to day program after 05-30-07. | am.  rding  eloped  MC &  ce will | 05-30-07                   |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIP<br>A. BUILDING | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|----------------------------|---|-------------------------------|----------------------------|
| ,   |   | 09G046  | B. WING                    |   | 05/1/                         | 0/2007                     |
|   | ROVIDER OR SUPPLIER   |   | 460                        | ET ADDRESS, CITY, STATE, ZIP CODE<br>01 GEORGIA AVENUE NW<br>ASHINGTON, DC 20011  | <u> </u>                      | 72001                      |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)                                 | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| W 120   | facility's BSP, date 9, 2007 at approximately hoarding was a target interventions were there was no evid coordinated with the Client #3's BSP for hoarding was bein 483.420(a)(3) PRORIGHTS  The facility must endividual clients to of the facility, and           | the psychologist. Review of the ed December 10, 2006 on May mately 7:15PM revealed that regeted behavior and that also documented in the plantience that the QMRP he day program to ensure that in the targeted behavior of | W 120                      |   |                               |                            |
|   | Based on staff interfacility failed to endeveloped to inform guardian of the client treatment, and the one of the four client. The finding include Interview with the Professional (QMI approximately 10: sister was active in consult, dated Octat approximately 1 | Qualified Mental Retardation<br>RP) on May 8, 2007 at<br>30AM revealed that Client #2's<br>in his life. Review of a medical<br>sober 11, 2006 on May 9, 2007<br>1:30AM revealed that Client                                 |                            | DCHC has already submitt<br>all the necessary papers<br>pertaining to legal<br>guardianship and the DDS<br>in the process of finalizing | is<br>it.                     | 01-28-07                   |
| •   | #2's sister signed however she was  | the consent for a colonoscopy,<br>not the legal guardian. Review<br>al assessment, dated May 22,  | . {                        | Please see attachment (A1 A2, A3)   | ,                             | Ongoing                    |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION<br>G | (X3) DATE SURVEY<br>COMPLETED   |            |                            |
|--|--|---|-----------------------|---|------------|----------------------------|
|  | 09G046   |   | B. WING               |   | 05/10/2007 |                            |
|  | ROVIDER OR SUPPLIER  |   | 4                     | REET ADDRESS. CITY, STATE, ZIP CODE<br>601 GEORGIA AVENUE NW<br>VASHINGTON, DC 20011                            |            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DÉFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                       | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |            | (X5)<br>COMPLETION<br>DATE |
| W 125  | 2006 on May 9, 200 revealed that Client to make decisions was no evidence the legally-sanctioned of the control | 77 at approximately 12:00PM ,<br>#2 did not cognitively unable<br>regarding his daily living. There | W 125                 |   |            |                            |
| W 159  | . 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.   |   | W 159                 | ·<br>   |            |                            |
|  | Based on observati<br>review the facility fa<br>treatment program<br>and monitored by the  | sional (QMRP) for one of four   |                       |   |            |                            |
|  | ensure Client#3 re   | V249. The QMRP failed to ceived consistent opportunities in new skills based on his                 | 1.                    | Please see the answer to W 249 on Pg # 5.   |            |                            |
| W 249  | Cross Refer to W120. The QMRP failed to coordinate Client #3's Behaviorial Support Plan with the day program     483.440(d)(1) PROGRAM IMPLEMENTATION  |   | 2.<br>W <b>249</b>    | Please see the answer to W120 on Pg # 2.  |            |                            |
|  |  | rdisciplinary team has<br>s individual program plan,  |                       |   |            |                            |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER;  | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  | (X3) DATE SU<br>COMPLE |                            |
|---|---|--|--------------------------|---|------------------------|----------------------------|
| •   |   | 09G046   | B. WING                  |   | 05/10                  | 0/2007                     |
|   | ROVIDER OR SUPPLIER   |  | 4                        | REET ADDRESS, CITY, STATE, ZIP CODE<br>801 GEORGIA AVENUE NW<br>VASHINGTON, DC 20011                              |                        |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)           | ULD BE                 | (X5)<br>COMPLETION<br>DATE |
| W 249   | each client must re<br>treatment program<br>interventions and s<br>and frequency to s   | age 4 ceive a continuous active consisting of needed cervices in sufficient number upport the achievement of the d in the individual program   | W 249                    |   |                        |                            |
|   | Based on observativerification, the faction, the faction, the factive out of four client and consistently enderning opportunit their skill levels for sample. (Client#3)  The finding include During observation Client #3 was observed on gestures to contract the client did demonstration. | is not met as evidenced by: dons, interviews, and record illity failed to demonstrated that nts in the sample are actively neouraged to engage in lies to maintain or enhance one of four clients in the les: les conducted on May 8-9, 2007, lerved using echolalia speech mmunicate with staff or peers, lonstrate the ability to follow lies staff, Interview staff |                          | An In-service training was given to all staff on 05/11/07. To encourage client # 3 to use VOCA machine to express |                        | 05-11-07                   |
|   | revealed that Clien speech, gestures a device. Interview of Retardation Profes at approximately 5 has a Voice Output to express his wan Client#3's Speech December 19, 200 approximately 11:4 was to use the VOineeds during all opevidence that Clien  | t #1 communicates with and uses a communication with the Qualified Mental asional (QMRP)on May 9, 2007 and Communication AID (VOCA) and needs. Review of and Language consult dated 6 on May 10, 2007 at 15AM revealed that the client CA to express his wants and apportunities. There was no not #1 was being encouraged to naintain his assessed strengths          |                          | his wants and needs during all the opportunities given. Please see attachment (B)                                 |                        |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES<br>AND PLAN OP CORRECTION |                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                   | (X2) MULTIPI<br>A. BUILDING | i cc  |                     | ATE SURVEY<br>DMPLETED     |  |
|---|------------------------------------|--|-----------------------------|---|---------------------|----------------------------|--|
| 09G046  |                                    |  | B. WING                     |   | 05/10 <u>/</u> 2007 |                            |  |
|   | ROVIDER OR SUPPLIER                |  | 460                         | EET ADDRESS, CITY, STATE, ZIP COI<br>01 GEORGIA AVENUE NW<br>ASHINGTON, DC 20011            |                     |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DÉFICIENC                    | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG               | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE           | (X5)<br>COMPLETION<br>DATE |  |
| W 249   | Continued From pain communication. | age 5  | W 249                       |   |                     |                            |  |
|   |                                    | ·  |                             |   |                     |                            |  |
|   |                                    |  | -                           |   |                     |                            |  |

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| STATEMENT OF DEFICIÊNCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING                      |                        | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|--|--|---|--|------------------------|--|------------|--------------------------|
|  | 09G046   |   | B, WING_   |                        | 05/1   | 05/10/2007 |                          |
| NAME OF PE   | ROVIDER OR SUPPLIER  |   | STREET ADI   | DRESS, CITY, S         | STATE, ZIP CODE  |            | OILOOI                   |
| D C HEAL   | LTH CARE   | •   | 1  | RĢIA AVEN<br>TON, DC 2 |  |            |                          |
| (X4) ID<br>PREFIX<br>YAG   | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>SC IDENTIFYING INFORM  | 'FULL  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED.TO THE APPROPRIATE<br>DEFICIENCY) |            | (X5)<br>COMPLETE<br>DATE |
| 1 000  | INITIAL COMMEN   | TS  |  | 1 000                  |  |            |                          |
|  | 8, 2007 through Mainitiated using the frandom sample of a resident population disabilities. The find based on observational staff in the horizontal staff in the horizontal staff. | rvey was conducted to<br>ay 10, 2007. The sur-<br>undamental survey p<br>four clients was select<br>on of eight men with<br>adings of the survey vi-<br>ions, interviews with<br>me and four day prog-<br>client and administra-<br>incident reports. | rvey was process. A cted from various were clients grams, as |                        |  |            |                          |
| 1 090  | 3504.1 HOUSEKE   | EPING   |  | 1 090                  |  |            |                          |
|  | maintained in a sat<br>and sanitary manne  | terior of each GHMR<br>fe, clean, orderly, attr<br>er and be free of<br>lirt, rubbish, and obje   | ractive,   |                        |  |            | ·                        |
| 4  | <ul> <li>Based on observating records, the facility</li> </ul>   | met as evidenced by<br>tions, interviews and<br>'s governing body prodirection over the fac<br>ving areas:  | review of ovided   |                        |  | ·          |                          |
|  | The finding include  | es:   |  |                        |  |            |                          |
|  |  | ly failed to ensure the<br>e facility's environme   |  |                        | Rusted fence around the building was painted on 05/12/07   |            | 05-12-07                 |
|  | a. Rust on the fend<br>the facility.   | cing around the perim   | neter of   |                        |  |            |                          |
| 1 437  | 3521.7(g) HABILIT  | ATION AND TRAIN   | ING  | 1437                   | ,  |            |                          |
|  | GHMRP shall inclu  | d training of resident<br>ide, when appropriat  |  |                        |  |            |                          |
| Health Regul   | ation Administration   | ey Shoph  |  |                        | TITLE  |            | (X6) DATE                |
| LABORATOR  |  | IDER/SUPPLIER REPRESE   |  | NATURE                 | Prest  | dear       | 5/23/                    |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING B. WING 09G046 05/10/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4601 GEORGIA AVENUE NW** D C HEALTH CARE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 1437 1437 Continued From page 1 be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required): This Statute is not met as evidenced by: Based on observations, interviews, and record verification, the facility failed to demonstrated that two out of four clients in the sample are actively and consistently encouraged to engage in learning opportunities to maintain or enhance their skill levels. The finding includes: During observations conducted on May 8-9. 2007. Client #3 was observed using echolalia speech and gestures to communicate with staff or peers. The client did demonstrate the ability to An In-service training was follow instructions from the staff. Interview staff given to all staff on 05/11/07. revealed that Client #1 communicates with 05-11-07 To encourage client #3 to use speech, gestures and uses a communication device. Interview with the Qualified Mental <u>VOCA</u> machine to express Retardation Professional (QMRP) on May 9, 2007 his wants and needs during all at approximately 5:30PM revealed that Client #3 the opportunities given. has a Voice Output Communication AID (VOCA) Please see attachment (B) to express his wants and needs. Review of Client#3's Speech and Language consult dated December 19, 2006 on May 10, 2007 at approximately 11:45AM revealed that the client was to use the VOCA to express his wants and needs during all opportunities. There was no evidence that Client #1 was being encouraged to use the VOCA to maintain his assessed strengths in communication.

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|                          |  | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUI                                |  | (X2) MULTI<br>A. BUILDIN<br>B. WING |  | (X3) DATE SURVEY COMPLETED  |                          |
|--------------------------|--|--|--|-------------------------------------|--|-----------------------------|--------------------------|
| 09G046                   |  |  | ,  |                                     |  | 05/10/2007                  |                          |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |  |                                     | STATE, ZIP CODE  |                             |                          |
| D C HEA                  | LTH CARE   |  |  | ORGIA AVEN<br>STON, DC 20           | ·  |                             |                          |
| (X4) ÍÐ<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIE<br>Y MUST BE PRECEDED BY<br>LSC IDENTIFYING INFORMA | FULL   | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORE<br>(EACH CORRECTIVE ACTION S<br>GROSS-REFERENCED TO THE AI<br>DEFICIENCY)  | HOULD BE                    | (X5)<br>COMPLETE<br>DATE |
|                          | Each GHMRP, in a provisions, shall as placement in an apemployment, or da Provided, that the pwith the resident 's This Statute is not Based on observatione and day provided, the facility failed to met the needs of o sample. (Client #3)  The facility failed to met the needs of o sample. (Client #3)  The facility failed to program was provided and the findings included program was provided attempting observed attempting picked up from the with day program approximately 1:15 hoards items that he program. The day they were not aware Behavioral Support home for hoarding to document the tay and company that the day program approximately Day protected the day program of the day | o ensure that Client#iding continuous activ                                | obtaining I, m; onsistent on Plan.  C: roup d review, services in the  3's day re on May 8, 3 was at he had nterview ent #3 n the day ed that a e group ucted staff ne ABC data dicated eir own not r. Review 07on May |                                     | A meeting was held with Q.M.R.P. & Day Program Psychologist / behavior specialist on 05/11/07 to address client # 3's hoard behavior.  A new BSP will be develoby the day program on 05/30/07 during their BM HRC meeting. In- service be given to day program after 05-30-07. | ing<br>oped<br>(C &<br>will | 05-30-07                 |

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/ČLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G046 05/10/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4601 GEORGIA AVENUE NW** D C HEALTH CARE WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID COMPLETÉ DATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 1454 1454 Continued From page 3 hoarding was not documented as a targeted behavior. Interview with the Qualified Mental Retardation Professional (QMRP)on May 9, 2007 at approximately 7:00PM revealed that the facility was not aware that the day program was not implementing Client#3's BSP for hoarding as recommended by the psychologist. Review of the facility's BSP, dated December 10, 2006 on May 9, 2007 at approximately 7:15PM revealed that hoarding was a targeted behavior and that interventions were also documented in the plan. There was no evidence that the QMRP coordinated with the day program to ensure that Client #3's BSP for the targeted behavior of hoarding was being implemented. 1500 3523.1 RESIDENT'S RIGHTS 1500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risk of treatment, and the right to refuse treatment for one of the four clients in the sample. (Client #2) DCHC has already submitted all the necessary papers 01-28-07 The finding includes: pertaining to legal guardianship and the DDS is Interview with the Qualified Mental Retardation Ongoing Professional (QMRP) on May 8, 2007 at in the process of finalizing it. approximately 10:30AM revealed that Client #2's Please see attachment (A1, sister was active in his life. Review of a medical A2, A3) consult, dated October 11, 2006 on May 9, 2007

Health Regulation Administration

STATE FORM

8T1611

PRINTED: 05/16/2007 FORM APPROVED

| AND PLAN OF CORRECTION   DENTIFICATION |   | (X1) PROVIDER/SUPPLIE<br>IDENTIFICATION NUM   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY<br>COMPLETED        |                          |
|--|---|---|---|--|--|--------------------------------------|--------------------------|
|  |   | 09G046  | OTREET AR                                   | DOEGO OFFICE                                     |  | 05/1                                 | 0/2007                   |
| 1                                      | ROVIDER OR SUPPLIER   |   | 4601 GEC                                    | DRESS, CITY, S<br>DRGIA AVEN<br>STON, DC 20      |  | <u>.</u>                             |                          |
| (X4) ID<br>PREFIX<br>YAG               | (EACH DÉFICIENC)  | ATEMENT OF DEFICIENCIES<br>O'MUST BE PRECEDED BY<br>SCIDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN C<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE! | CTION SHOULD BE<br>O THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
|  | #2's sister signed the however she was not the Psychologica 2006 on May 9, 200 revealed that Client to make decisions. There was no evide legally-sanctioned ghealth care decision the colonoscopy. | age 4  1:30AM revealed that the consent for a color to the legal guardian at assessment, dated or at approximately 1 #2 did not cognitively regarding his daily livience the client had a guardian and/or a surn-maker to review or | noscopy, Review May 22, 2:00PM, unable ing. | I 500  |  |                                      |                          |
| nesiin Kegul                           | ation Administration  |   |   |  |  |                                      |                          |